| | 26/2012 10:46 8655945739 | | HEA | LTH CARE FACILITY | PAGE | 04/09 |
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| DEPA | RTMENT OF HEALTH AND HUMAN SERV | /ICES 🦯 | MC | 9/3/12. | PRINTED: | 07/25/2013 |
| CENT | ERS FOR MEDICARE & MEDICAID SERV | <u>ICES</u> | <i>,,</i> — | 112/12 | | APPROVE(0938-039 |
| ISIATEME | NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIES | RICH FA | (X3) M1 | ALTIPLE CONSTRUCTION | DINIB NO. | |
| 0. | OF CORRECTION NUM | 個部 | A. BUIL | | COMPLE | |
| 1100 | .4 | | 1 | 6 | , | С |
| MAME OF | PROVIDER OR SUPPLIER | | B. Verjui | <u> </u> | 1 | 0/2012 |
| 1 | | | ٠ . | STREET ADDRESS, CITY, STATE, ZIP CODE | | <u> </u> |
| GREYS | TONE HEALTH CARE CENTER | | . 1 | 181 DUNLAP ROAD, PO BOX 1133 | | |
| (X4) ID | Class | <u> </u> | | BLOUNTVILLE, TN 37617 | | |
| PREFIX | (EACH DEFICIENCY MIGT DE ODECRARA | ~~· | iD PREFIX | PROVIDER'S PLAN OF CORRECT | TION | (7(5) |
| TAG | REGULATORY OR LSC IDENTIFYING INFORMAT | NON) | TAG | (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR | JLD BE OPRIATE | (XE) COMPLETION OATE |
| | | <u> </u> | | DEFICIENÇY) | | |
| F 241 | 483.15(a) DIGNITY AND RESPECT OF | [| | Please consider this plan of | correction | . 1. 1 |
| \$\$=0 | INDIVIDUALITY | | F 24 | Greystone's Health Care Center's | | 3/9/2017 |
| 1 | | - 1 | | allegation of compliance under | | • |
| · i | The facility must promote care for residen | nts in a | | la a re | uírements. | |
| ł | manner and in an environment that maint | ams or | | Submission of this plan of correction | | ŕ |
| | enhances each resident's dignity and resp full recognition of his or her individuality. | pect in | | indulation of that a decision | n is not an | |
| | i i i i i i i i i i i i i i i i i i i | } | | admission of that a deficiency exis | | |
| 1 | 7 | - | | the facility agrees they were cited | | |
| | This REQUIREMENT is not met as evide by: | nced | | This plan of correction reflects the | | |
| 1 | Based on medical record review, observa | | | continually enhance the quality | | |
| | and interview, the facility failed to provide | ition, | | services provided to the residents | | • |
| 1 | for one (#6) of six residents reviewed. | oignity | | submitted solely as a requiremen | nt of the | i |
| | } | | | provisions of Federal and state law. | | |
| | The findings included: | i | | ł | | · |
| į į | Resident #6 was admitted to the facility on | 1_ | | • | | J |
| [. |) 93116817 25, 2012, and re-edimination at al., | (' | ころりし | Corrective Action and Identify area | s having | j |
| | ~~ '4', will diagnoses mehating Malifals As | Park Indian | | the potential to be affected: | | i |
| | VESCURA ACCIDENTS (CVA) Rechirches Est | 7 | | | | [|
| 1 1 | Pneumonia, Tracheotomy, Colostomy, Uro and Dysphagia (difficulty swallowing). | sepsis, | | Resident #6's colostomy bag was cha | anged on | i |
|] [| | } | | 6/26/2012. Products will be used for | resident | } |
| 1 1 | Observation in the resident's room and nea | ir the | | #6 to reduce the odor when air is | | |
| | JESIDERIES DOOT IN the hallway on time or . | Anso I | | from the colostomy bag. |] | |
| | at 10:30 a.m., revealed a strong fecal odor. | | | | 1 | |
| | Observation on June 26, 2012, at 10:25 a.n. | n in | | Identifying Other Residents | | } |
| 1 | VIC I POWERLES TOOM WITH LEARNING MILLION AND | | | | 1 | i |
| | (UNA) #1 and Licensed Practical Nurse it of | DATE MA | | Two additional residents colostomy p | | [|
| | revealed a strong fecal odor. Interview with #1 and LPN #1 while in the resident's room | CNA | | were reviewed by the unit manag | | 1 |
| į i | CONTINUED the odor and revesion the salary. | 1 | | determined the odors were contained | l . | |
| 11 | from "burping" the resident's colostomy bag | | | | | |
| | | | į | , | 1 | |
| | Observation on June 26, 2012, at 3:30 p.m., the resident's room with the resident's visitor | , in | | | | ļ |
| | confirmed the odor and that it came from the | r | ļ | | } . | |
| | | | .] | | | - 1 |
| ABOHATORY I | DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIV | VES SIGNATIO | RE J | , t TITLE | | |
| TYV | serve Bus | | - | A 1 . | · · · · · · · · · · · · · · · · · · · | DATE |
| ny deficiency | Statement engine with an actorick (*) denotes a con- | | | Administrator | 813 | 12017 |

Any deficiency sistement ending with an asteriek (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their sefeguards provide sufficient protection to the patients. (See instructions.) Except for againing the date of survey whether or not a plan of correction is provided. For nursing homes, the findings stated above are disclosable 90 days lays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

ORM GMS-2567(02-98) Previous Versions Obsoleta

Event RX UYBV11

Facility ID: TNB204

If continuation sheet Page 1 of 5

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| 97/26/2012 | | 8655945739 | HEALTH CARE FACILIT |
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| DEPARTMENT O | F HEALTH | AND HUMAN SERVICES | |
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| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | | | APPROVED . 0938-0391 |
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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIENCLIA IDENTIFICATION NUMBER: | | (XZ) M A. BiJil | | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| | | 445242 | 8. WIN | IG | | L | C 0/2012 |
| | PROVIDER OR SUPPLIER FONE HEALTH CARE | CENTER | | 11 | EET ADDRESS, CITY, STATE, ZIP CODE BY DUNLAP ROAD, PO BOX 1123 LOUNTVILLE, TN 37617 | | <u> </u> |
| (X4) ID PREFIX TAG | i (EALM DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREPO TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRICACES OF THE AP | JLD BE | COMPLETION COMPLETION |
| F 241 | resident's colostom Observation and into 7:25 a.m., outside o | and it was "embarrassing." Prview, on June 27, 2012, at the resident's more in the | F 2 | 41 | Systemic Changes: Unit managers will review resid colostomies twice a week for 2 w weekly for 4 weeks then mont | eeks then | |
| F 281 SS=D | #2 revealed a strong LPN #2 while in the odor was from "burp and was not respect 483.20(k)(3)(i) SERV PROFESSIONAL ST | the resident's room with LPN odor of feces. Interview with resident's room confirmed the ring" the resident's colostomy fing the resident's dignity. ICES PROVIDED MEET | | ; ; ; | months to determine if proceed propropriate and odors contained. The staff development coordinates to the staff development coordinates are complete education with the licens and certified nursing assistance ancontrolled adors from colostomy monitoring: | ator will ed nurses to report | |
| | by: Based on medical re | it is not met as evidenced scord review and interview, slow a physician's order for ents reviewed. | | f. f. | tesults of the audits will be review acility QA&A Committee meeting or 3 months with revisions to the leemed appropriate by the committee. | monthly e plan as | |
| | o, 2012, for short terr for a tom Rotator Cut Medical record review dated June 12, 2012. | nitted to the facility on June in rehabilitation after surgery f. | | | he Director of Nursing and unit in the presponsible for overall compliance. | | |
| 1 | Medical record review Medication Administration revealed the ear drop administered on June | ear qd (every day) X (times) of the June 2012, ation Record (MAR) s were scheduled to be 13, 14, and 15, and then used. Continued review | | | · · · · · · · · · · · · · · · · · · · | - | |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FACILITY

PAGE 86/89

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| OMB NO | 0938-0391 |
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| CENTERS FOR MEDICARE | | | OMB NO. 0938-039 |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY |
| 11.1.1.1 | The state of the s | A BUILDING | COMPLETED |
| | 445242 | B. WING | C C |
| NAME OF PROMIDED OF SUPPLIED | | <u> </u> | 07/20/2012 |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDENSUPPLIENCIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) Mil A. BUIL | ULTIPLE CONSTRUCTION . | (X3) DATE SI GOMPLE | URVEY | |
| | | 445242 | B. WIN | G | | Ċ |
| NAME OF | PROVIDER OR SUPPLIER | | · · · · · · · · · · · · · · · · · · · | | | 0/2012 |
| Į. | | | ŀ | STREET ADDRESS, CITY, STATE, ZI | P GODE | |
| GREYST | ONE HEALTH CARE | CENTER | | 181 DUNLAP ROAD, PO BOX 1 | 132 | |
| <u>-</u> | | | | BLOUNTVILLE, TN 37617 | | |
| (X4) FD PREFDX TAG | | | PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DETICIENT | TION SHOULD BE THE APPROPRIATE | (XX) COMPLETION DATE |
| | <u> </u> | | | Corrective Action and Ide | entify areas having | -21.26 |
| F 281 | Continued From pa | | F 20 | 81 the potential to be affected | d. | 8)412017 |
| 1 | revealed no initials | indicating the nurse | | - The potential to be affected | ,a ; | |
| | administered the ea | ar drops on June 13, 14, or 15, | 1 | Posidont #1/a - Luciaira | | |
| | 2012. | • | | Resident #1's physician | 1 | 1 |
| Į | l | | [| order received for debrox | and placed on the | |
| Į., i | Interview on June 26, 2012, at 3:15 p.m., in the hallway near the third floor nurse's desk, with the third floor Unit Manager revealed the nurse who worked on June 13, 2012, could not remember administering the ear drops, the nurse who worked on June 14 and 15, 2012, administered the ear drops on the June 15, 2012, but forgot to | | | medication administrati | ion record on | i i |
| • | | | | 6/27/2012. | | |
| | | | | V, 2.7 2.022. | | j |
| | | | | Identifying Other Residents | | ŀ |
| | | | | identitying Other Nesidents | ' ! | |
| | | | | Unit managers revier | | |
| | sion the MAD Con- | ter interview with the third | | | | |
| | floor Unit Manager | Confirmed the ear drops were | | administration records for | documentation of | |
| | not administered as | the physician ordered. | | medications being administ | trated to residents. | i |
| F 441 | 483.65 INFECTION | CONTROL, PREVENT | 7 | j | i | |
| SS≍D | SPREAD, LINENS | CONTROL PREVENT | , | Systemic Changes: | | ł |
| | ,,, | | | _ | j | 1 |
| | The facility must osl | ablish and maintein an | | The facility unit manager | s will complete a | . 1 |
| . f | Infection Control Pro | ogram designed to provide a | | weekly audit for 4 weeks | | - ! |
| į | Safé, Sanitary and o | omfortable environment and | | | | 1 |
| 1 | to nelp prevent the (| evelopment and transmission | | for 8 weeks of the medicat | | 4 |
| | of disease and infec | tion. j | | records for completion | and appropriate | 1 |
| İ | (a) infaation Course | Description | | documention. | [| - 1 |
| 1 | (a) Infection Control | abilish an Infection Control | | | 1 | ł |
| ļ. | Program under which | Parieties de l'infection Coutroi | | The DON educated the faci | ility administrative | |
| | (1) Investigates con | trols, and prevents infections | | | the medication | |
| ļ | in the facility; | and and brosons unectolis | | administration records. | | j |
| | | ocedures, such as isolation, | | | | 1 |
| 1 | should be applied to | an individual resident and | | development coordinat | | j |
| | (3) Maintains a recor | d of incidents and corrective | • | education with the license | d nursing staff on: | 1 |
| Ţ | actions related to inf | infections. | | administration of m | edications and | 1 |
| | /h) Dwww.co.eth.co.eh | | | documentation on t | he medication | J |
| į | (b) Preventing Spread(1) When the Infortion | d of Infection | | administration records. | | . [|
| i. | (1) When the infection | sident needs isolation to | | administration records. | | [|
| | nowant the corner o | f infection, the facility must | | 1 | | - 1 |
| | prevent the spread o | · imedian, tre facility most | | | j | 1 |

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isolate the resident.

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HEALTH CARE FACTUATY

PAGE 07/09

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| | | AND HUMAN SERVICES 8 MEDICAID SERVICES | | | FORM | 07/25/2012 APPROVED _0938-0391 |
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER: | | | (XX) MUI | TIPLE CONSTRUCTION | (XXI) DATE SURVEY COMPLETED | |
| 445242 | | | B. WING | | C. 97/20/2012 | |
| NAME OF P | PROVIDER OR SUPFLIER | | s | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| GREYST | ONE HEALTH CARE | CENTER | | 181 DUNLAP ROAD, PO BOX 1133 BLOUNTVILLE, TN 37617 | | |
| (X4) 10 PREFIX TAG | (MACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREMX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOTH CROSS-REFERENCED TO THE APPRICAL DEFICIENCY) | TION` ULD BE OPRIATE | (X5) COMPLETION CATE |
| F 441 | ((p | | F281 | Monitoring: | | 8/9/2002 |
| | (2) The facility must | t prohibit employees with a | ļ · | Results of the audits will be reviewed by the | | , ,, ,, , |
| | from direct contact: | ase or infected skin lesions with residents or their food, if | ļ | facility QA&A Committee mont | hly for 3 | |
| | direct contact will the | ansmit the disease | Ì | months with revisions to the plan | as deemed | j j |
| | (3) The facility must | t require staff to wash their rect resident contact for which licated by accepted | | appropriate by the QA&A Committe | e e. | |
| | Moressional braces | e. | | 1 | | - |
| | (c) Linens | | İ | The Administrator, Director of N | - 1 | |
| | Personnel must har transport linens so a infection. | ndle, store, process and as to prevent the spread of | | unit managers will be responsible compliance. | for overall | |
| | | | | Corrective Action and Identify are | eas having | 8/9/2012 |
| ŀ | This REQUIREMEN by: | IT is not met as evidenced | F441 | the potential to be affected: | | 0111201- |
| | and interview, the fa | record review, observation, ucility failed to provide vent contamination for one reviewed. | | On 6/27/2012 Resident #6-the uni removed the formulas and suction i the resident's care area and discard | tems from | |
| | The findings include | d: | | Identifying Other Residents | | |
| | Resident#6 was add | mitted to the facility on | | | Ì | |
| | January 25, 2012, at | nd re-admitted on May 27. | | On 6/27/2012 resident rooms were | | i |
| ļ | 2012, with diagnose | s including Multiple Cerebral | | by nursing and housekeeping for ite | ms at the | } |
| İ | vascular Acquents (Multiple Enisodes of | (CVA), Respiratory Failure, Pneumonia, Urosepsis, | | bedside that needed discarded. | | |
| | Tracheotomy, Colos | torny, Dysphagia (difficulty) Tube Placement (feeding | | | | |

tube inserted into the stomach).

Medical record review of the hospital's History and Physical dated June 13, 2012, revealed the resident was hospitalized with Pneumonia and Urosepsis (severe urinary tract infection).

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HEALTH CARE FACILITY.

PAGE 08/09 PRINTED: UTZSIZUTA FORM APPROVED OMB NO. 0938-0391

| PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Systemic Changes: | | | AND HUMAN SERVICES | | • | | | MAKOA≅n |
|--|---|---|--|-------|--|---|---|--------------------|
| A SULDING A HOLD OF PROVIDER OR SUPPLIER GREYSTONE HEALTH CARE CENTER CALL OF PROVIDER OR SUPPLIER GREYSTONE HEALTH CARE CENTER CALL OF PROVIDER STATE ADDRESS, CTY, STATE, 2P CODE 381 DURLLAP ROAD, PO BOX 1133 BLOUNTVILLE, TH 37617 CALL OF PROVIDERS FLAT OF CONCRUSCION (INCHESTED AND MARKET OF CONCRUSCION) (INCHESTED AND MARKET | CENTER | S FOR MEDICARE | | | | | | _ |
| NAME OF PROVIDER OR SUPPLIER GREYSTONE HEALTH CARE CENTER C(4) DD PREST ADDRESS, CITY, STATE JP CODE STRUMLAP ROAD, PO 80X 1133 BLOUNTVILLE, TN 37817 FACT CONTINUED TO DEPRICE SHOW STRUML APPROPRIATE CONSTRUCTION SECULATORY OR LOCI DEMNISTRING INFORMATION) F 441 Continued From page 4 Observation on June 27, 2012, at 7:20 a.m., in the resident's tracheostomy on the bedside table, tubing approximately four foot long (with formula in it) on the floor, and formula spilled on the foor container of Normal Salino used to suction container of Normal Salino was open, containinated, and available for licensed staff to use to suction the resident. F 441 An audit will be completed by the unit managers and housekeeping to observe resident care areas for breaches in infection control techniques. This audit will be completed twice weekly for 2 weeks, then weekly for 2 weeks then monthly for three months. The staff development coordinator completed education with the nursing staff, housekeeping staff and respiratory staff regarding infection control techniques to prevent spread of infection to residents. Monitoring: Results of the audits will be reviewed by the facility QA&A Committee monthly for 3 months with revisions to the plan as deemed appropriate by the QA&A Committee. The Administrator, Director of Nursing and infection control nurse and unit managers will | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA . UND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | , | | | COMPLETED | | |
| SUMMARY STATEMENT OF DEPLEMENTS (CA) D (CA) | • | | 445242 | B. WI | NG_ | | _ | |
| CONTRIBUTION AREALTH CARE CENTER CONTRIBUTION SUBMERTY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LOC IDENTIFYING INFORMATION) F 441 Continued From page 4 Observation on June 27, 2012, at 7:20 a.m., in the resident's room with Licensed Practical Nurse (LPN) #2 and LPN #3, revealed an open container of sterile Normal Salino used to suction the resident's tracheostomy on the bedside table, tubing approximately four foot long (with formula in it) on the floor, and formula spilled on the floor. Interview on June 27, 2012, at 7:20 a.m., in the resident's room with LPN #2 and #3, confirmed the formula in the tubing and on the floor provided a breading ground for bacteria, and the open container of Normal Saline was open, container of Normal Saline was open, container of Normal Saline was open, container of the resident. BLOUNTVILLE, TN 37617 PREPRY RECHARD FLOOR SCHOLLES (RECHARD TO THE APPROPRIATE COMPLETE OF THE APPROPRIATE CENTER CONTAINED TO THE APPROPRIATE CENTER CONTAINED TO THE APPROPRIATE CENTER CHORD SHOULD BE CENTER CHORD SHOULD BE CENTER CHORD TO THE APPROPRIATE CENTER CHORD SHOULD BE CENTER CHORD SHOULD | NAME OF P | ROVIDER OR SUPPLIER | | ··· | | | -· · · | |
| F 441 Continued From page 4 Observation on June 27, 2012, at 7:20 a.m., in the resident's room with Licensed Practical Nurse (LPN) #2 and LPN #3, revealed an open container of sterile Normal Salino used to suction the resident's tracheostomy on the bedside table, tubing approximately four foot long (with formula in the tubing and on the floor provided a breeding ground for bacteria, and the open container of Normal Saline was open, container of Normal Saline was open. The staff development coordinator completed education with the nursing staff, housekeeping staff and respiratory staff regarding infection control techniques to prevent spread of infection to residents. Monitoring: Results of the audits will be reviewed by the facility QA&A Committee monthly for 3 months with revisions to the plan as deemed appropriate by the QA&A Committee. The Administrator, Director of Nursing and infection control nurse and unit managers will | GREYST | ONE HEALTH CARE | CENTER | | 1 | | | |
| Continued From page 4 Observation on June 27, 2012, at 7:20 a.m., in the resident's room with Licensed Practical Nurse (LPN) #2 and LPN #3, revealed an open container of sterile Normal Saline used to suction the resident's tracheostomy on the bedside table, tubing approximately four foot long (with formula in it) on the floor, and formula spilled on the floor. Interview on June 27, 2012, at 7:20 a.m., in the resident's room with LPN #2 and #3, confirmed the formula in the tubing and on the floor provided a breeding ground for bacteria, and the open container of Normal Saline was open, contaminated, and available for licensed staff to use to suction the resident. F 441 An audit will be completed by the unit managers and housekeeping to observe resident care areas for breaches in infection control techniques. This audit will be completed twice weekly for 2 weeks, then weekly for 2 weeks then monthly for three months. The staff development coordinator completed education with the nursing staff, housekeeping staff and respiratory staff regarding infection control techniques to prevent spread of infection to residents. Monitoring: Results of the audits will be reviewed by the facility QA&A Committee monthly for 3 months with revisions to the plan as deemed appropriate by the QA&A Committee. The Administrator, Director of Nursing and infection control nurse and unit managers will | PRÉFIX | GRACH DEFICIENCY MUST BE PRECEDED BY FULL | | | PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE | | | COMPLETION DATE |
| be responsible for overall compliance. | TAG | Continued From particles of the resident's room (LPN) #2 and LPN container of sterile the resident's track tubing approximate in it) on the floor, a interview on June resident's room withe formula in the tab breeding ground container of Normal contaminated, and | nge 4 ne 27, 2012, at 7:20 a.m., in with Licensed Practical Nurse #3, revealed an open Normal Salino used to suction reostomy on the bedside table, by four foot long (with formula and formula spilled on the floor. 27, 2012, at 7:20 a.m., in the in LPN #2 and #3, confirmed tubing and on the floor provided for bacteria, and the open at Saline was open, available for licensed staff to | TAG | | Systemic Changes: An audit will be completed by managers and housekeeping the resident care areas for breaches control techniques. This audit completed twice weekly for 2 weekly for 2 weekly for 2 weekly for 2 weekly for 2 weekly for 2 weekly for 2 weeks then monthly months. The staff development completed education with the nethnousekeeping staff and respirately regarding infection control techniques. Monitoring: Results of the audits will be revieted facility QA&A Committee monthmonths with revisions to the plan appropriate by the QA&A Committee. The Administrator, Director of Minfection control nurse and unit means the sum of the plan appropriate in the plan appropriate by the QA&A Committee. | y the unit to observe in infection t will be weeks, then by for three coordinator ursing staff, atory staff hniques to dents. wed by the thly for 3 as deemed tee. | 8/9/2012 |
| | , | | | J | | be responsible for overall complian | nce. | |